TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 10, 1907.

The President, Dr. George Woolsey, in the Chair.

INTUSSUSCEPTION.

Dr. J. D. Rushmore presented a boy, 13 years of age, who was seized about 5 A.M., January 8, with severe paroxysmal pains in the abdomen. He was up and about during the first few hours and after that kept his bed. Vomiting soon began and the vomited matter consisted at first of food (mostly custard pie, a large quantity of which he had eaten the evening before), then bilious and brownish fluid without much odor; bowels failed to act naturally or by enema or cathartics; no gas was passed; took no nourishment and slept little. There was tenderness and distension of the abdomen. No passage of blood or mucus from the bowel, and no desire to go to stool. A tumor does not seem to have been recognized until the 13th, five days after the onset of the symptoms.

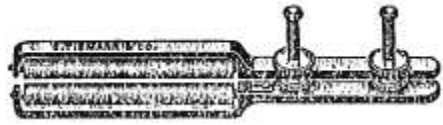
Entered hospital late in the evening of January 13, at which time his temperature was 97½°; pulse 90 and of fairly good quality; face pale; abdomen tense, some distension, large tumor, rather ill-defined but tender, on the left side following the direction of the descending colon, but nearer the median line. Immediate laparotomy through left rectus muscle, and the delivery of a large iliac mass, very dark in color, well distended, and twisted on its mesentery. With some difficulty the intussusceptum was by traction and pressure delivered from its sheath, and about an ounce of very dark and offensive fluid escaped and soiled the intestine and mesentery. This fluid was sponged off with gauze

and saline solution. The intussusceptum was found empty and gangrenous, but not perforated.

The contents of the bowel, solid, fluid, and gaseous, were pushed back from the gangrenous area by a pair of intestinal roller-clamps made by Tiemann & Co. Each clamp consists of two rollers revolving freely in their respective frames. By means of four check nuts these frames can be rigidly held in any position, the two guides constantly keeping them parallel; the rollers therefore exert a uniform pressure across the intestine when it is clamped between them. The surface of the rollers is slightly roughened to overcome any tendency to slide, and by a simple slide at the handle portion of the instrument they can be released from their bearings to facilitate sterilizing. The total length of the instrument is about 5¼ inches, and the line of contact of the two rollers is 2½ inches. (Fig. 1.)

The healthy intestine on each side of the gangrenous portion was slipped between the rollers and the rollers were screwed

FIG. 1.



together sufficiently to merely bring the opposite walls of the gut into coaptation; then by steadying the gangrenous portion with a long Keith's forceps the clamp was rolled away about 5 inches and screwed down a little in order to avoid slipping. The intestine between the clamp and forceps was flat and empty. The gangrenous part was thus excised in the usual way, except that any deep cut into the mesentery, which was not gangrenous, was avoided, and thus secured a better vascular supply of the ends to be sutured. A continuous glovers' silk suture was used to unite the cut ends, and a secondary continuous Lembert's peritoneal suture of the same material was introduced and the clamp was removed; the intestine was replaced and the abdominal wound was closed by layer sutures.

The clamp worked to entire satisfaction. It was easily and quickly applied, did not damage the wall of the intestine, and its use avoids the risks of a tape ligature, which necessitates a perforation of the mesentery with the possibility of injuring a vessel

and the necessity of suturing the wound after the removal of the tape. If, however, the clamp is screwed down too tight at first there is probably a danger of tearing the peritoneal coat of the intestine when the clamp is rolled. This accident will not occur if the clamp is properly used. It might be better to screw the clamp tight at first, cut between the clamp and forceps, and not do the rolling until the gangrenous mass has been removed and the sutures are to be employed. The field of operation will then be left free from more or less mucus that always escapes between the clamp or forceps or tape and the cut end of the intestine. If this method is employed a narrow strip of gut that may have been pressed on unduly by the clamp can be trimmed off, giving a fresh surface for the suture. It has also been suggested that the intestine might be emptied by substituting the first or ring and middle fingers for the clamp; but it is doubtful if the fingers will do the work as satisfactorily as the clamp.

After the dressings were applied the boy was put to bed with a pale and perspiring skin and a pulse of 180. Artificial heat and adrenalin solution hypodermically were employed, with good effect. The temperature was 102° on the morning following the operation and gradually dropped from day to day and reached 98° on the fifth day, with a slight evening rise for a few days. The pulse dropped gradually, but rose again about three weeks after the operation for a few days from no apparent cause. Fæcal vomiting occurred on the first day, then ceased after a thorough gastric lavage. Rectal alimentation until the third day, when the rectum became irritable and the patient voided involuntarily three or four large and bloody and very fetid stools. Water to quench thirst was used from the first, but not always retained. On the fourth day egg albumin was tried by the stomach and retained. After that the history is of a rapid convalescence. He left the hospital February 15, somewhat anæmic and weak, and has been gaining strength and flesh since, with a little sluggishness in bowel action. The length of the resected portion of the intestine was 40 inches.

ACUTE INTESTINAL OBSTRUCTION FROM STRANGULATION OF MECKEL'S DIVERTICULUM.

Dr. George Emerson Brewer presented a boy, 8 years old, who was admitted to the Roosevelt Hospital in February, 1907, suffering from acute intestinal obstruction. He had always